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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CAROLE L. SLETTEN 28513 Lemon Avenue Escalon, CA 95320 Registered Nurse License No. 583480 Respondent.	Case No. 2009-153 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about July 16, 2001, the Board issued Registered Nurse License Number 583480 to Carole L. Sletten ("Respondent"). Respondent's registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2011, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions . . .

6. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. At all times relevant herein, Respondent was employed as a registered nurse at Sutter Tracy Community Hospital ("STCH"), Tracy, California.

9. On or about November 16, 2005, patient "# K006905" was admitted to Gambaro Dialysis Center ("GDC") and diagnosed with a clotted dialysis shunt. The patient was transferred to STCH for insertion of a temporary dialysis catheter. After the temporary catheter was placed, the treating doctor assigned the Respondent to flush the catheter. Catheters are flushed with Heparin. Heparin is an anticoagulent and blood thinner used primarily to prevent blood clots in catheter lines and is listed on the hospital pharmacy's list of "High Alert/High Risk Medications". Respondent was not familiar with the catheter nor the proper dosage of heparin to flush the catheter. Respondent checked STCH's policy and procedure manual but STCH did not have a policy and procedure for heparin instillation and dialysis catheters. Respondent then contacted STCH's Clinical Educator, Kim Bailey, who did not know the proper dosage. Ms. Bailey contacted GDC who advised that the catheter lines had printed dosage information on the lines and that the concentration should be 5,000 ml of heparin. Ms. Bailey relayed this information to the Respondent. The Respondent read the numbers printed on each port incorrectly. As a result of incorrectly reading the dosage, the Respondent instilled 9 ml of 5,000 units per ml of heparin instead of the correct amount of 2.9 ml of 5,000 units of heparin per ml.. The patient was dialyzed that evening, but the process was not completed because of problems with the temporary dialysis catheter.

10. On the morning of November 17, 2005, the patient began showing symptoms of physical distress necessitating emergency diagnosis and treatment. The patient's physical condition degenerated to the point a Code Blue was initiated. The patient's symptoms improved but a subsequent cranial CAT scan revealed the patient had a cerebral bleed that was subsequently determined to likely be the result of the excessive dose of heparin. The patient's medical status continued to degrade and ultimately the patient expired.

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11. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that on or about November 16, 2005, while employed as a registered nurse at STCH, Respondent was committed gross negligence within the meaning of Regulation 1442, as follows:

a. Respondent administered an incorrect dose of heparin to the patient resulting in physical and medical harm to the patient.

b. Respondent administered a High Risk/High Alert medication, heparin, to the patient without a second registered nurse confirming the proper dosage.

c. Respondent failed to consult reference books, publications or computer resources to confirm the dose of a High Alert/High Risk medication, heparin, was within recommended standards and where the Respondent was not familiar with the catheter.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 8 through 10 above.

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that on or about November 16, 2005, while employed as a registered nurse at STCH, Respondent committed acts constituting unprofessional conduct, as set forth in paragraph 11 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 583480, issued to Carole L. Sletten;

2. Ordering Carole L. Sletten to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 1/8/09.

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

03579-110-SA2008304401
phd; 10/23/2008